

City of Houston Medical Plan Comparison for Retirees

Coverage	HMO Plan	Medicare Advantage Plans		Preferred Provider Organization	
		TexanPlus	Texas HealthSpring	In-Network	Out-of-Network
Who is eligible? For a list of eligible dependents see enrollment guide, p. 12.	Retirees and eligible dependents who are currently enrolled in a city-sponsored medical plan and live in HMO Blue Texas Service Area.	Retirees and eligible dependents who are currently covered by a city-sponsored medical plan with Medicare A & B coverage. Must also live in the service area. Persons who have end-stage renal disease may not join this plan. If a person joins the plan and later develops end-stage renal disease, the member may remain a member of TexanPlus or Texas HealthSpring.		Retirees and eligible dependents who are currently enrolled in a city-sponsored medical plan.	
What is the service area?	Plan covers all but 34 counties in the state of Texas. See the HMO directory for a list of counties in the service area, or visit the Web site at www.bcbstx.com.	Brazoria, Fort Bend, Galveston zip codes: 77510, 77511, 77517, 77518, 77539, 77546, 77549, 77563, 77565, 77568, 77573, 77574, 77590, 77591, 77592, Harris, Hardin, Jefferson County, Montgomery County, Orange County	Angelina, Brazoria, Cameron, Chambers, Fort Bend, Galveston, Harris, Hardin, Hidalgo, Jasper, Jefferson, Liberty, Montgomery, Nacogdoches, Orange, Polk, San Jacinto, Walker, Waller	There are 49 states in the service area. Montana is not covered. A reduced benefit and higher deductibles apply for services obtained out-of-network. To identify participating providers outside of Texas, call 1-800-810-2583 or use your zip code to find a provider at www.bcbstx.com.	
Does the plan cover participants out of the service area?	Yes, in the event of a medical emergency notify HMO Blue Texas within 48 hours of initial treatment. Seek services within 12 hours after the onset of an illness or within 48 hours after an accident.	Yes, but only in the event of a medical emergency. TexanPlus must be notified as soon as possible.	Yes, but only in the event of a medical emergency. Texas HealthSpring must be notified as soon as possible.	Yes, participants are covered at home or away, 24-hours a day, using their choice of physicians. A reduced benefit and higher deductibles apply for services obtained out-of-network. To identify participating providers outside of Texas, call 1-800-810-2583.	
What are the annual deductibles?	None.	None.	None.	Individual: \$200 Family: \$600	Individual: \$400 Family: \$1,200
Office Visits	\$20 copay for primary care physician. \$45 copay for specialist.	• \$5 for each PCP office visit for Medicare-covered services. • \$25 for each specialist visit for Medicare-covered services.	• \$10 for each PCP office visit for Medicare-covered services. • \$25 for each specialist office visit for Medicare-covered services.	\$30 copay for primary care physician. \$50 copay for specialist.	40% after annual deductible.
Routine Physicals / Check-ups	\$20 copay.	• \$5 for each PCP office visit and one routine physical exam annually for Medicare-covered services. • \$25 for each specialist visit for Medicare-covered services. • \$0 for a one-time physical exam within the first 6 months that you have Medicare Part B, if your coverage began on or after 1/1/06.	• \$10 for each PCP office visit and one routine physical exam annually for Medicare-covered services. • \$25 for each specialist office visit for Medicare-covered services.	\$30 copay plus 20% in the physician's office.	40% after annual deductible.
Hospital Emergency Room Charges per visit?	\$150 per visit (waived if admitted to the hospital). You must notify your PCP or BCBS within 48 hours. Physician's office after hours: \$20 per visit.	• \$50 for each Medicare-covered emergency room visit; waived if admitted within 48 hours for the same condition. • NOT covered outside the U.S. except under limited circumstances.	• \$50 for Medicare-covered emergency room visit; waived if admitted within 3 days for the same condition. • World-wide emergency care If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a plan hospital with plan authorization.	\$150 copay plus 20% for emergency within 48 hours of accident/medical emergency. Illness anytime. Copay waived if admitted to hospital.	\$150 copay plus 40% after deductible for emergency after 48 hours of the accident/medical emergency. Copay waived if admitted to hospital.
Urgent Care for Minor Emergencies	Office Visits: \$20 copay Urgent Care Center: \$40 copay	• \$50 for each Medicare-covered urgently needed care visit. • Copayment waived if admitted within 24 hours for the same condition. • Coverage available at any urgent care facility. NOT covered outside the U.S. except under limited circumstances.	• \$40 for each Medicare-covered urgently needed care visit. • Copayment waived if admitted within 3 day(s) for the same condition. • World-wide coverage	Office Visits: \$30 copay Urgent Care Center: \$60 copay	Office Visits: 40% after annual deductible Urgent Care Center: 40% after annual deductible.
Ambulance Service	\$100 Copay	\$50 for each Medicare-covered ambulance one-way service.	\$100 for each Medicare-covered one-way ambulance service; you do not pay this amount if you are admitted to the hospital.	Eligible expenses at 20% after annual deductible.	Eligible expenses at 40% after annual deductible is met.
Inpatient Hospital Admissions	\$500 copay per hospital admission. Pre-authorization required.	• \$300 for each Medicare-covered stay in a network hospital. No copayment for additional days. Covered for unlimited days each benefit period.	• \$275 for each Medicare-covered stay in a network hospital. No copayment for additional days. Covered for unlimited days each benefit period. • If you are readmitted to the hospital within 3 days for the same diagnosis your copay will be waived.	20% after \$500 copay per admission. Pre-authorization required.	40% after \$1,000 copay per admission. Pre-authorization required. \$250 copay for failure to get pre-authorization
Outpatient Surgery	\$200 copay for each procedure. Pre-authorization is required.	\$125 for each Medicare-covered visit or procedure to an ambulatory or outpatient hospital facility.	\$200 for each Medicare-covered visit or procedure to an ambulatory surgical center or outpatient hospital facility.	20% after annual deductible for each procedure. Pre-authorization required.	40% after annual deductible for each procedure.
Long-term acute care (LTAC)	N/A	• \$300 per LTAC admission for the first 60 days of the LTAC admission (waived if LTAC admission is a transfer from an Inpatient acute care setting) • \$228 per day for days 61-90 per benefit period • \$456 per each lifetime reserve day (maximum 60 lifetime reserve days)	• \$0 for 1-15 days • \$50 for 16+ days	N/A	N/A
Skilled Nursing Facility	\$25 per day. (Maximum of 60 days per calendar year.)	• \$0/day for day(s) 1 – 20 with immediate prior inpatient acute care. • \$100/day for day(s) 21-100 • \$300/day for day (s) 1 – 20 No prior hospital stay is required. You are covered for 100 days each benefit period.	• \$25/day for day(s) 1-100 for a stay in a skilled nursing facility • No prior hospital stay is required. You are covered for 100 days each benefit period.	Eligible facility expenses subject to \$500 hospital inpatient copayment; 20% thereafter. Copayment waived for transfer from inpatient hospital level of care to a skilled nursing level of care. Services other than those provided by skilled nursing facility, such as attending physician's services, are subject to 20% coinsurance after the deductible. Coverage is limited to the following conditions: If participant were not admitted to a skilled nursing facility, acute care hospitalization would be needed, the attending physician authorizes the care and the administrator <u>pre-authorized</u> the care. Coverage is also limited to a maximum of 60 days per calendar year. Custodial care or care for persistent illnesses and disorders that, in the administrator's opinion, cannot be relieved or improved by medical treatment, are not covered.	Eligible facility expenses subject to \$1,000 hospital inpatient copayment; 40% thereafter. Copayment waived for transfer from inpatient hospital level of care to a skilled nursing level of care. Services other than those provided by skilled nursing facility, such as attending physician's services, are subject to 40% coinsurance after the deductible. Coverage is limited to the following conditions: If participant were not admitted to a skilled nursing facility, acute care hospitalization would be needed, the attending physician authorizes the care and the administrator <u>pre-authorized</u> the care. Coverage is also limited to a maximum of 60 days per calendar year. Custodial care or care for persistent illnesses and disorders that, in the administrator's opinion, cannot be relieved or improved by medical treatment, are not covered.
Home Health	\$20 copay for each visit. Pre-authorization required.	There is no copayment for Medicare-covered home health visits.	There is no copayment for Medicare-covered home health visits.	Skilled, non-custodial home health care services are 20% after annual deductible. Limited to 60 visits per calendar year. Pre-authorization required.	Skilled, non-custodial home health care services are 40% after annual deductible. Limited to 60 visits per calendar year. Pre-authorization required.
Hospice	\$0 copay. Pre-authorization required. Maximum benefit of \$20,000.	\$0 copayment in a Medicare-certified hospice facility.	\$0 copayment in a Medicare-certified hospice facility.	Inpatient: Eligible expenses subject to \$500 hospital inpatient copayment and 20%. Outpatient: Eligible expenses, \$30 copayment. Services other than those provided by hospice facility, such as attending physician's services, are subject to 20% after the plan deductible.	Inpatient: Eligible expenses subject to \$1000 Hospital Inpatient Copayment and 40%. Outpatient: Eligible expenses, 40% after deductible. Services other than those provided by hospice facility, such as attending physician's services, are subject to 40% after plan deductible.
Body Distortion Services/Chiropractic Services	\$20 copay. No maximum amount.	\$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).	\$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).	Office Visit: 20% after \$30 copay. Other Services: 20% after annual deductible in outpatient setting. Combined annual limit is \$1,000 per calendar year, including all X-rays, lab, medicines, etc.	Office Visit: 20% after annual deductible. Other Services: 40% after annual deductible in outpatient setting.
Inpatient Mental Health Services	If deemed medically necessary \$500 copay per admission. 30 days maximum per calendar year. Pre-authorization required.	\$300 for each Medicare-covered stay in a network hospital. There is a 190-day lifetime limit in a psychiatric hospital. The benefit days used under the Original Medicare program will count towards the 190-day lifetime reserve days when enrolling in TexanPlus.	\$275 for each Medicare-covered stay in a network hospital. There is a 190-day lifetime limit in a psychiatric hospital. The benefit days used under the Original Medicare program will count towards the 190-day lifetime reserve days when enrolling in Texas HealthSpring.	20% after \$500 copay per admission. 30 days maximum per calendar year. Pre-authorization required.	40% after \$1,000 copay per admission. 15 days maximum per calendar year. Pre-authorization required.
Outpatient Mental Health Services Note: Emergency Room visits will require Emergency Room Copay.	Office Visit: \$25 copay per session. Maximum of 20 sessions per calendar year.	For Medicare-covered mental health services, you pay \$35/individual per visit and \$20/group per therapy visit.	For Medicare-covered mental health services, you pay \$25/individual per visit and \$25/group per therapy visit.	Office Visit: 20% after \$30 copay. 30 visits maximum per calendar year, includes outpatient visits.	Office Visit: 40% after annual deductible. 30 visits maximum per calendar year, includes outpatient visits. Pre-authorization required. \$250 additional copay for no authorization.
Chemical Dependency Services/Substance Abuse	Emergency Room: \$150 copay. Copay waived if admitted. Office Visit: \$20 copay. Inpatient: \$500 copay for each admission. Limited to 3 series of treatments per lifetime of individual. Pre-authorization required.	Emergency Room: \$50 for each Medicare-covered emergency room visit; waived if admitted within 48 hours. NOT covered outside the U.S. except under limited circumstances. Office Visit: \$35 per individual visit and \$20 per group therapy visit for Medicare-covered services. Inpatient: \$300 for each Medicare-covered stay in a network hospital. No copay for additional days. Covered for unlimited days each benefit period.	Emergency Room: \$50 for Medicare-covered emergency room visit; waived if admitted within 3 days. World-Wide Emergency Care. Office Visit: \$25 for each individual/group therapy visit. Inpatient: \$275 for each Medicare-covered stay in a network hospital. Covered for unlimited days each benefit period. If readmitted to the hospital within 3 days for the same diagnosis, copay will be waived.	Emergency Room: 20% after \$150 copay. Copay waived if admitted. Office Visit: 20% after \$30 copay. Inpatient: 20% after \$500 copay for each admission. Limited to 3 series of treatments per lifetime of individual.	Emergency Room: 40% after \$150 copay and after deductible. Copay waived if admitted. Office Visit: 40% after annual deductible. Inpatient: 40% after \$1,000 copay for each admission. Limited to 3 series of treatments per lifetime of individual. Pre-authorization required. \$250 additional copay if not pre-authorized.
Physical Therapy	\$20 copay per visit. Unlimited physical therapy visits that continue to meet or exceed treatment goals set by physician. For physically disabled persons, treatment goals may include maintaining function or preventing or slowing further deterioration. Pre-authorization required.	\$25 for each Medicare-covered Occupational Therapy visit. \$25 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.	\$25 for each Medicare-covered Occupational Therapy visit. \$25 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy and cardiac rehabilitation visit.	Office visit: 20% after \$30 copay. Outpatient: 20% after deductible Unlimited physical therapy visits that continue to meet or exceed treatment goals set by physician. For physically disabled persons, treatment goals may include maintaining function or preventing or slowing further deterioration. Pre-authorization required.	40% after deductible. Unlimited physical therapy visits that continue to meet or exceed treatment goals set by physician. For physically disabled persons, treatment goals may include maintaining function or preventing or slowing further deterioration. Pre-authorization required.

Medicare Advantage Plan



Making SMART health choices



Suitable for all Medicare retirees 1 or more members required

Use the chart below to find the contribution for the coverage you elect. First, look for the category in the left-hand column that fits your situation, then select the corresponding rate for the plans of your choice. If you have family members who remain in the HMO or PPO, select the rate based on the age of the oldest family member keeping the HMO or PPO plan. Your total monthly contribution is the sum of the rate for HMO or PPO, plus the rate for TexanPlus or Texas HealthSpring. These rates also apply to Medicare-covered retirees/dependents under age 65.

*Rates displayed for the HMO and PPO are for participants who do not use tobacco products. If the participant or a family member uses tobacco products, the rate is \$25 higher per month. This additional amount does not apply to TexanPlus or Texas HealthSpring.

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Coverage	HMO Plan	Medicare Advantage Plans		Preferred Provider Organization																																																																	
		TexanPlus	Texas HealthSpring	In-Network	Out-of-Network																																																																
Durable Medical Equipment	Eligible expenses covered with a 20 percent copay for rental or purchase (initial placement only) of such equipment when pre-authorized and determined to be medically necessary by BCBS. Rental or purchase is determined by BCBS. Coverage is limited to equipment listed in the Coverages Issue Manual. Covers hearing aid benefit of \$1,000 per 36-month period.	10% of the cost for each Medicare- covered item.	10% of the cost for each Medicare-covered item.	Eligible expenses are 20% after annual deductible for rental or purchase (initial placement only) of such equipment when pre-authorized and determined to be medically necessary by BCBS. Coverage is limited to equipment listed in the Health Care Finance Administration Coverages Issue Manual. Covers hearing aid benefit of \$1,000 per 36-month period.	Eligible expenses are 40% after annual deductible for rental or purchase (initial placement only) of such equipment when pre-authorized and determined to be medically necessary by BCBS. Coverage is limited to equipment listed in the Health Care Finance Administration Coverages Issue Manual. Covers hearing aid benefit of \$1,000 per 36-month period.																																																																
Diabetic Equipment, Self-Monitoring and Training Supplies	Diabetic equipment: 20% of eligible charges Diabetic supplies: same as prescription drug coverage below Diabetes Self-Management Training Programs: \$0 copayment	Diabetic self-monitoring training: \$0 copayment Diabetic equipment: 10% of eligible charges Diabetic supplies: 10% of the cost for each covered item Injectable insulin (31-day supply): <ul style="list-style-type: none">• \$10 generic• \$30 brand	Diabetic self-monitoring training: \$0 copayment Diabetic equipment: 10% of eligible charges Diabetic supplies: 20% of the cost for each covered item Injectable insulin (30-day supply): <ul style="list-style-type: none">• \$10 generic• \$30 brand	Eligible expenses at 20% after \$30 copayment. Diabetic equipment, self-management training and supplies are covered on the same basis as benefits are provided for treatment of other analogous chronic medical conditions. Also covered: disposable or consumable outpatient diabetic supplies, equipment and supplies that do not require a prescription under state law, and injectable insulin.	Eligible expenses at 40% after deductible is met. Diabetic equipment, self-management training and supplies are covered on the same basis as benefits are provided for treatment of other analogous chronic medical conditions. Also covered: disposable or consumable outpatient diabetic supplies, equipment and supplies that do not require a prescription under state law, and injectable insulin.																																																																
Lab & X-rays	\$0 copay. Included in physician’s office visit.	<ul style="list-style-type: none">• \$0 for specimen drawing or each covered laboratory service• \$75 for each MRI, MRA, CT Scan• \$100 for each IMRT• \$150 for each PET Scan• \$25 for each Medicare-covered radiation therapy• \$0 for each Medicare-covered X-ray visit in the physician’s office or freestanding facility	<ul style="list-style-type: none">• \$0 for specimen drawing, lab service• \$25 for each Medicare-covered radiation therapy• \$0 for each Medicare-covered X-ray visit in the physician’s office or freestanding facility• \$150 for each PET scan• \$100 for each MRI, CT or cardiac nuclear medicine scan	Office Visit: \$30 copay Outpatient: \$0 copay includes independent lab and x-ray.	40% after annual deductible.																																																																
Bone Mass Measurement	\$20 copayment	\$0 copayment		\$30 copayment.	40% after annual deductible is met.																																																																
Colorectal Cancer Screening (Includes fecal occult blood test, a flexible sigmoidoscopy and colonoscopy)	\$0 copay for age 50 and older or members with risk factors: <ul style="list-style-type: none">• Fecal occult blood test –every year• Flexible sigmoidoscopy –every 5 years.• Colonoscopy –every 10 years.	\$0 copayment for age 50 and older: <ul style="list-style-type: none">• Flexible sigmoidoscopy – every 48 months.• Fecal occult blood test–every 12 months. Member with risk factors: Colonoscopy every 24 months. Member with low risk factors: Colonoscopy every 10 years.		\$0 copay for age 50 and older or members with high risk factors: <ul style="list-style-type: none">• Fecal occult blood test – every year.• Flexible sigmoidoscopy – every 5 years.• Colonoscopy –every 10 years.	40% after annual deductible for age 50 and older or members with high risk factors: <ul style="list-style-type: none">• Fecal occult blood test – every year.• Flexible sigmoidoscopy –every 5 years.• Colonoscopy –every 10 years.																																																																
Routine Immunizations	\$0 copayment if service provided during an office visit when recommended by the American Academy of Pediatrics and U. S. Public Health Service. Otherwise a \$20 copayment applies.	<ul style="list-style-type: none">• \$0 copayment for the Pneumonia and Flu vaccines.• No referral necessary for Pneumonia and Flu vaccines.• \$0 copayment for the Hepatitis B vaccine.		\$0 copayment to age 6. After age 6, \$30 copayment when recommended by the American Academy of Pediatrics and U. S. Public Health Service.	\$0 copay to age 6. After age 6, 40% after annual deductible when recommended by the American Pediatrics and U. S. Public Health Service.																																																																
Well-Woman Exam (includes clinical breast exams, mammogram, pelvic exam & pap smear)	\$0 copay (one exam per 12 months). Mammogram-over age 40 or family history of breast cancer exists.	<ul style="list-style-type: none">• \$0 copayment for Medicare-covered screening: pap smear, breast exam or mammogram every 24 months.Age 40 and older: Breast exam or mammogram every 12 months.Members with high risk cervical cancer factors and are of childbearing age: Pap smear every 12 months.No referral necessary for Medicare-covered screenings performed by a network provider.		\$0 copayment. (one exam per 12 months). Mammogram-over age 40 or family history of breast cancer exists.	40% after annual deductible. (one exam per 12 months). Mammogram-over age 40 or family history of breast cancer exists.																																																																
Well-Man Exam – Prostate Cancer Screening for age 50 and older. (includes prostate examination & prostate specific antigen test)	\$0 copay- one exam per 12 months. (Includes members age 40 with a family history of prostate cancer or prostate cancer risk factors)	\$0 copayment for Medicare-covered exams once every 12 months.	\$0 copayment for Medicare covered exams once every 12 months.	\$0 copay-every 12 months. (includes members age 40 with a family history of prostate cancer or prostate cancer risk factors)	40% after annual deductible –every 12 months. (Includes members age 40 with a family history of prostate cancer or prostate cancer risk factors)																																																																
Prescriptions:	<table><thead><tr><th>Drug category</th><th>HMO (30-day supply)</th><th>TexanPlus (31-day supply)</th><th>Texas HealthSpring (30-day supply)</th></tr></thead><tbody><tr><td colspan="4">Prescriptions</td></tr><tr><td>Generic</td><td>\$10</td><td>\$10</td><td>\$10</td></tr><tr><td>Preferred brand</td><td>\$30</td><td>\$30</td><td>\$30</td></tr><tr><td>Non-preferred brand</td><td>\$45</td><td>\$45</td><td>N/A</td></tr><tr><td>Specialty drugs</td><td>\$45</td><td>\$45</td><td>\$45*</td></tr><tr><td colspan="4">Prescriptions (90-day supply) mail-order copayment</td></tr><tr><td>Generic</td><td>\$20</td><td>\$20</td><td>\$20</td></tr><tr><td>Preferred brand</td><td>\$60</td><td>\$60</td><td>\$60</td></tr><tr><td>Non-preferred brand</td><td>\$90</td><td>\$90</td><td>N/A</td></tr><tr><td>Specialty drugs</td><td>\$90</td><td>\$90</td><td>\$90*</td></tr><tr><td colspan="4">Prescriptions special copayments</td></tr><tr><td>Medicare Part B</td><td>Included under “Non-preferred brand” copayments listed above</td><td>20% up to \$1,500</td><td>15% up to \$1,000</td></tr></tbody></table> <p>* Prior authorization required</p>			Drug category	HMO (30-day supply)	TexanPlus (31-day supply)	Texas HealthSpring (30-day supply)	Prescriptions				Generic	\$10	\$10	\$10	Preferred brand	\$30	\$30	\$30	Non-preferred brand	\$45	\$45	N/A	Specialty drugs	\$45	\$45	\$45*	Prescriptions (90-day supply) mail-order copayment				Generic	\$20	\$20	\$20	Preferred brand	\$60	\$60	\$60	Non-preferred brand	\$90	\$90	N/A	Specialty drugs	\$90	\$90	\$90*	Prescriptions special copayments				Medicare Part B	Included under “Non-preferred brand” copayments listed above	20% up to \$1,500	15% up to \$1,000	Retail (30 day supply): <table><thead><tr><th></th><th>Participating Pharmacy</th><th>Non-Participating Pharmacy</th></tr></thead><tbody><tr><td>• Generic Drug</td><td>\$10 copay</td><td>50% after \$20 copay</td></tr><tr><td>• Preferred Brand Name</td><td>\$30 copay</td><td>50% after \$20 copay</td></tr><tr><td>• Non-Preferred Brand Name</td><td>\$45 copay</td><td>50% after \$20 copay</td></tr></tbody></table> Mail-order (90-day supply): All maintenance prescription drugs prescribed for more than 30 days may be filled by Prime Therapeutics mail order program. Participants pay \$20 for generic, \$60 for preferred brand and \$90 for non-preferred brand per 90-day supply. Mandatory generic unless written as “Dispense as Written.”			Participating Pharmacy	Non-Participating Pharmacy	• Generic Drug	\$10 copay	50% after \$20 copay	• Preferred Brand Name	\$30 copay	50% after \$20 copay	• Non-Preferred Brand Name	\$45 copay	50% after \$20 copay
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Vision Services	Vision screenings \$0 copay - coverage for members under age 18. Features: <ul style="list-style-type: none">• \$3 copayment for routine eye exam every 12 months• Copayments for frames and lenses are based on fee schedule.	Features: <ul style="list-style-type: none">• \$25 for each routine eye exam, limited to 1 exam every year.• \$25 for annual glaucoma screening for high risk patients• \$25 for symptomatic ophthalmologic services• \$0 post-cataract surgery eyeglass lenses and/or contact lenses requiring intraocular lenses• \$50 for eyeglass frames after each cataract surgery requiring intraocular lenses.	Features: <ul style="list-style-type: none">• \$0 copay for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery)• \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye)• \$25 for annual glaucoma screening for high-risk patients.	Features: <ul style="list-style-type: none">• Eligible expenses at \$30 copay when performed by physician for members under age 18.• Not covered: Exams for glasses, contact lenses or vision.	Features: <ul style="list-style-type: none">• Eligible expenses are 40% after annual deductible when performed by physician.• Not covered: Exams for glasses, contact lenses or vision.																																																																
Hearing Services	Hearing screenings \$0 copay - coverage for Members under age 18. One audiometric exam to determine type and extent of hearing loss once every 36 months. Plan pays \$1,000 for hearing device once every 36 months.	<ul style="list-style-type: none">• \$25 for each Medicare-covered Specialty Care Physician hearing exam (diagnostic hearing exams).• Member pays pay 100% for routine hearing exam and hearing aids.	<ul style="list-style-type: none">• \$25 for each Medicare-covered hearing exam (diagnostic hearing exams).• Member pays 100% for routine hearing exams.	Eligible expenses at \$30 copay when performed by physician for members under age 18. Not covered: Exams for hearing aids, hearing, speech, etc.	Eligible expenses at 40% after annual deductible when performed by physician. Not covered: Exams for hearing aids, hearing, speech, etc.																																																																
Transplants	Doctor’s office: \$20 copay Specialist: \$45 copay Outpatient facility: \$200 copay Inpatient facility: \$500 copay	<ul style="list-style-type: none">• \$912 copay per confinement (then 100% coverage up to 60 days)• \$228 additional copay per day (then 100% coverage for 61-90 days)• \$456 additional copay per each lifetime reserve day (then 100% coverage for maximum 60 lifetime reserve days)	<ul style="list-style-type: none">• \$952 copay per confinement (then 100% coverage up to 60 days)• \$238 additional copay per day (then 100% coverage for 61-90 days)• \$476 additional copay per each lifetime reserve day (then 100% coverage for maximum 60 lifetime reserve days)	Doctor’s office: \$30 copay Specialist: \$50 copay Outpatient facility: 20% Inpatient facility: 20% after \$500 copay	Doctor’s office: 40% after annual deductible Outpatient facility: 40% after annual deductible Inpatient facility: 40% after \$1,000 copay																																																																
What is the annual maximum out-of-pocket amount that I will pay? What are the annual combined coinsurance/ deductible maximum for the PPO? (add all coinsurance, deductibles and eligible copayments)	Individual: \$1,500 Family: \$3,000 Excluding copays for prescription drugs, inpatient mental health and other supplemental riders (eg. Vision care, prescription drug and durable medical equipment).	Individual: \$1,500 The following services apply: <ul style="list-style-type: none">• Inpatient hospital care• Inpatient mental health care• Skilled nursing facility• Home health care• Chiropractic services• Podiatry services• Outpatient mental health care• Outpatient substance abuse care• Outpatient services• Ambulance services• Emergency services• Urgently needed care• Outpatient rehabilitation services• Durable medical equipment• Prosthetic devices• Cardiac rehabilitation services• Renal dialysis• Diabetic self-monitoring training and supplies• Comprehensive outpatient rehabilitation facility (CORF)• Partial hospitalization These out-of-pocket costs do not apply: <ul style="list-style-type: none">• Medicare Part B outpatient prescription drug copayments or coinsurance• Copayments for PCPs and specialists• Outpatient prescription drugs• All other services not listed	Individual: \$1,500 The following services apply: <ul style="list-style-type: none">• Inpatient hospital care• Inpatient mental health care• Skilled nursing facility• Home health care• Chiropractic services• Podiatry services• Outpatient mental health care• Outpatient substance abuse care• Outpatient services• Ambulance services• Emergency care• Urgently needed care• Outpatient rehabilitation services• Durable medical equipment• Prosthetic devices• Cardiac rehabilitation services• Renal dialysis• Diabetic self-monitoring training and supplies• Comprehensive outpatient rehabilitation facility (CORF)• Partial hospitalization Diagnostic test, X-rays, and lab services These out-of-pocket costs do not apply: <ul style="list-style-type: none">• Medicare Part B outpatient prescription drug copayments or coinsurance• Copayments for PCPs and specialists• Outpatient prescription drugs• All other services not listed	Individual: 3,000 Family: \$6,000 Excluding copays for prescription drugs.	Individual: \$5,000 Family: \$10,000 Excluding copays for prescription drugs.																																																																
After I reach my annual out-of-pocket maximum, will I continue to pay any coinsurance or copayments?	Yes. You will always pay the copayments for prescription drugs and vision care, durable medical equipment and inpatient mental health.	Yes. You will always pay the copayments for outpatient prescription drugs and PCP/specialist visits and any other services not listed above.	Yes. You will always pay the copayments for outpatient prescription drugs and PCP/specialist visits and any other services not listed above.	Yes. You will always pay the copayments for physician office visits, prescription drugs, inpatient hospital stays, urgent care and emergency room services.	Yes. You will always pay the copayments for physician office visits, prescription drugs, inpatient hospital stays, urgent care and emergency room services.																																																																
May plan participants select physicians, specialists, and hospitals of their choice?	Plan participants may choose primary care physicians (PCP) and pharmacies that are in the HMO network. All care must be coordinated by your PCP. The PCP must refer you to other providers and specialists who are in the same IPA as the PCP. Female plan members may self-refer to OB/GYN in the PCP’s group for their annual well-woman examinations. Note: Changes in the selection of your PCP will be effective the first of the following month.	<ul style="list-style-type: none">• You must go to network doctors, specialists, and hospitals.• You must choose a primary care physician (PCP)• All care must be coordinated by your PCP.• PCP must refer you to other providers and specialists who are in the same PCP group.• Referral needed to go to network hospitals for non-emergency care and certain doctors, including specialist for certain services.• You do not need a referral when you have a medical emergency. You should seek treatment at the nearest medical facility.• You may change your PCP at any time, the change will be effective the first of the month following your request to change.	<ul style="list-style-type: none">• You must go to network doctors, specialists, and hospitals.• You must choose a primary care physician (PCP)• All care must be coordinated by your PCP.• PCP must refer you to other providers and specialists who are in the same PCP group.• Referral needed to go to network hospitals for non-emergency care and certain doctors, including specialist for certain services.• You do not need a referral when you have a medical emergency. You should seek treatment at the nearest medical facility.• You may change your PCP at any time, the change will be effective the first of the month following your request to change.	Plan participants may choose physicians, hospitals, pharmacies and other medical providers that are members of the PPO network. Contact BCBS for assistance in locating a provider or view www.bcbstx.com. Participants may choose a provider out-of-network, the doctor may be a ParPlan provider contracted with BCBS to provide reduced or discounted fees.	Participants may select the provider, hospital or pharmacy of their choice. If the provider is not in the PPO network, the doctor may be a ParPlan provider contracted with BCBS to provide reduced or discounted fees.																																																																
Transportation	N / A	N / A	\$0 copayment to provide 30 one-way trips to plan-approved locations every year.	N / A																																																																	
Value Added Services	N / A	HearPO Hearing Discount Services: <ul style="list-style-type: none">• 30% discount on hearing exams and services• Up to 62% savings on hearing aids at a participating provider• Discounts on repairs and batteries.• Access to newest digital technology. Locate a hearing provider at 1-800-456-6801 Hearing Aid: <ul style="list-style-type: none">• TexanPlus will pay a one-time \$500 cash payment per covered member for the purchase of a hearing aid.• You may use any hearing aid provider; however, you can receive up to a 62 percent discount if you go to HearPO. To receive your reimbursement, submit a copy of the receipt for your hearing aid to TexanPlus, and they will send a check to you for up to \$500. EyeMed Vision Services: <ul style="list-style-type: none">• Discounted vision services and eye care.• This includes a \$25 copay for an annual eye exam and discounts on frames and lenses.• Look on page 95 of your provider directory for a list of network eye doctors. Careington Dental Discount Services: <ul style="list-style-type: none">• Receive 20% - 50% off most dental procedures.• Up to 20% discount on specialty services• Cosmetic dentistry and teeth whitening included.• 24,000 participating providers.• Locate a dental provider at 1-800-290-0523 ElderCare Services - NurseNavigator: <ul style="list-style-type: none">• Works with you to identify elder-care needs• Evaluate options, put solutions in place.• Provide on-going support needed to maintain independence and quality of life.• Wellness assessments, care planning tools.• 24-hour Nurse Navigator elder-care advisor• Significant discounts on senior housing alternatives & additional care services	Fitness Benefit: Members may enroll in Silver Sneakers Fitness program that allows them access to health clubs and participate in classes specifically designed for Seniors. <ul style="list-style-type: none">• Upon enrollment the member will be provided with numerous fitness and health centers in the local area.• Full use of amenities including free weights, tread mills, aerobic classes, as well as fitness programs specifically tailored for the needs of seniors• A customer service department ready to answer any questions regarding the program and to assist with enrollment.• Provide up to a 30% discount for hearing aids at selected providers. Careington Dental Discount Services: <ul style="list-style-type: none">• Receive 20% - 50% off most dental procedures.• Up to 20% discount on specialty services.• Cosmetic dentistry and teeth whitening included.• 24,000 participating providers.• Locate a dental provider at 1-800-290-0523. Free Rides: <ul style="list-style-type: none">• Free rides are provided to plan-approved health facilities, such as doctor’s appointments, hospitals, and pharmacies. Up to 30 one-way trips or 15 round trips per calendar year. Discount Hearing Aids: <ul style="list-style-type: none">• Discount hearing services provide up to 30%.• Discount for hearing aids from selected providers. PAL–Personal Assistant Liaison: <ul style="list-style-type: none">• PALs proactively engage members in THS’ benefits plan. PALs will “reach out” to members and encourage them to use plan benefits, educate them about programs and services, and resolve members’ problems.	N / A																																																																	
What is the lifetime maximum benefit per person?	None	None	None	\$1,500,000 per participant. Lifetime maximum does not apply to coverage or services for AIDS or human immune deficiency virus infection																																																																	

Note: If there exists a conflict between this Medical Plans Comparison and the official plan documents for each plan, the official plan documents will prevail. In all matters of coverage, only eligible expenses will be covered and paid according to plans provision. If pre-authorizations are required for medical services, penalties will apply if those services are received without authorization.

The City of Houston reserves the right to change or modify benefits provided under these plans without consent, authorization or prior notice to covered members. TexanPlus and Texas HealthSpring provide additional benefits. For a complete listing of all benefits and services, please refer to the Evidence of Coverage for the plan that you select.

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